Drs. Barbell, PA
2301 Evesham Road, Suite 404
Voorhees, NJ 08043
856-489-8990

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

DATE _____

PATIENT INFORMATION

Name_____ Birthdate_____SS#_____
Address_____ City_____ State_____ Zip_____
Sex ◯ M ◯ F ◯ Married ◯ Widowed ◯ Single ◯ Minor
◯ Separated ◯ Divorced ◯ Partnered
Cell Phone_____ Home Phone_____ Email_____
Employer_____ Employer Phone_____
Employer Address_____ City_____ State_____ Zip_____
Spouse or Parent's Name_____ Employer_____ Work #_____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____

RESPONSIBLE PARTY

Person Responsible for this Account_____ Relation to Patient_____
Address_____ Phone_____
Birthdate_____ Currently a patient in our office? ◯ Yes ◯ No
Employer_____ Work Phone_____
Email_____ Cell Phone_____

DENTAL INSURANCE INFORMATION

Name of Insured_____ Relation to Subscriber_____
Birthdate_____ Soc. Sec. #_____
Employer_____ Work #_____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Subscriber ID#_____ Group #_____
Address_____ City_____ State_____ Zip_____

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured_____ Relation to Subscriber_____
Birthdate_____ Soc. Sec. #_____
Employer_____ Work #_____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Subscriber ID#_____ Group #_____
Address_____ City_____ State_____ Zip_____

DENTAL HISTORY

Reason for today's visit_____ Date of last dental care_____
Former Dentist_____ Date of last dental x-rays_____
Address_____
Check if you have or had problems with any of the following:

◯ Bad Breath	◯ Grinding Teeth	◯ Sensitivity to Hot
◯ Bleeding Gums	◯ Loose Teeth or Broken Fillings	◯ Sensitivity to Cold
◯ Clicking or Popping Jaw	◯ Periodontal Treatment	◯ Sensitivity when Biting
◯ Food Collecting Between Teeth	◯ Sores or Growths in Mouth	◯ Sensitivity to Sweets

How often do you floss?_____ How often do you brush?_____

MEDICAL HISTORY

Physician's Name_____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fasfin (brand name of phentermine), Fintepla (fenfluramine) and Redux (dexfenfluramine). ◯ Yes ◯ No

Have you ever had any serious illnesses or surgeries? ◯ Yes ◯ No If yes, describe_____
Have you ever had a blood transfusion? ◯ Yes ◯ No If yes, approximate dates_____

(Women) Are you pregnant? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No Taking birth control pills? ◯ Yes ◯ No

Check (√) if you have or have had problems with any of the following:

◯ Anemia	◯ Congenital Heart Lesions	◯ Hepatitis	◯ Scarlet Fever
◯ Arthritis, Rheumatism	◯ Cortisone Treatments	◯ Hernia Repair	◯ Shortness of Breath
◯ Artificial Heart Valves	◯ Cough, Persistent	◯ High Blood Pressure	◯ Skin Rash
◯ Artificial Joints, Pins, etc.	◯ Cough up Blood	◯ HIV/AIDS	◯ Stroke
◯ Asthma	◯ Diabetes	◯ Jaw Pain	◯ Swelling of Feet/Ankles
◯ Back Problems	◯ Epilepsy	◯ Kidney Disease	◯ Thyroid Problems
◯ Bleeding Abnormally	◯ Fainting	◯ Liver Disease	◯ Tobacco Habit
◯ Blood Disease	◯ Glaucoma	◯ Mitral Valve Prolapse	◯ Tonsillitis
◯ Cancer	◯ Headaches	◯ Pacemaker	◯ Tuberculosis
◯ Chemical Dependency	◯ Heart Murmur	◯ Radiation Treatment	◯ Ulcer
◯ Chemotherapy	◯ Heart Problems	◯ Respiratory Disease	◯ Venereal Disease
◯ Circulatory Problems	◯ Hemophilia	◯ Rheumatic Fever	◯ Other _____

List ALL medications you are currently taking:

_____ _____
_____ _____
_____ _____

Allergies:

◯ Aspirin	◯ Local Anesthetic	◯ Iodine	◯ Other _____
◯ Barbiturates (Sleeping Pills)	◯ Penicillin	◯ Latex	_____
◯ Codeine	◯ Sulfa	◯ None	_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Date

Drs. Barbell, P.A.

Patient Financial Policy & Agreement

****ALL ESTIMATED FEES ARE DUE AT THE TIME OF SERVICE****

FOR PATIENTS WITH DENTAL INSURANCE:

We will gladly verify your dental benefits and process your primary and secondary insurance claims with the following agreement:

- Your dental insurance is an agreement between you and your insurance company.
- You, the patient, are responsible for knowing the terms and conditions of your insurance plan contract as well as bearing the financial responsibility of your account.
- All patient copayments and/or patient portions are only an estimate , never a guarantee, of payment.
- As part of your contract with your insurance company, you are responsible for all out-of-pocket portions/copayments and deductibles.
- Insurance payments not paid after 90 days will become your responsibility and must be paid in full.
- As a courtesy to you we will process all your insurance claims. By signing this form, you give us permission to assign dental benefit payments to be paid directly to Dr. Barbell from your insurance company.

IF WE ARE NOT BILLING DENTAL INSURANCE:

- Treatment must be paid in full at time of service.

PAYMENT OPTIONS:

- For your convenience, we accept Visa, Mastercard, Discover, American Express, Care Credit, checks or cash (exact change please)

MISSED APPOINTMENTS:

- Please remember that your appointment time has been reserved specifically for you. We reserve the right to charge a fee for cancelled or missed appointments without 24-hour notice.
- We reserve the right to discharge patients from our practice who repeatedly fail to either come for a scheduled appointment or give appropriate notice.

COLLECTION FEES:

- In the event your account becomes past due, it will be referred to an outside collection agency. The account holder will be responsible for all collection costs, attorney fees, court costs or any other fees incurred by Drs. Barbell.

GUARANTEE OF WORK:

- Dr. Barbell guarantees dental crowns, bridges, dentures, and implant work for 18 months after the service has been completed, provided you have maintained 2 regularly scheduled preventive appointments annually.

I understand and agree to this Financial Policy and Agreement

_____

Signature of Patient, Parent, Guardian or Responsible Party Date